

**Improving Health Insurance Markets
and Promoting Competition
Under Health Care Reform**

Statement of

Linda J. Blumberg, Ph.D.

**Senior Fellow
The Urban Institute**

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Mr. Chairman and distinguished Members of the Committee: Thank you for inviting me to share my views on health insurance markets and health care reform. The views I express are mine alone and should not be attributed to the Urban Institute, its trustees, or its funders.

Current health insurance markets suffer from many shortcomings. I'm going to focus my remarks on three that I believe are central, and what I think we might be able to do under reform to address them. First the private insurance system is a voluntarily one for both employers and insurers, but too often those who would like to buy coverage face significant barriers to doing so, including lack of affordability and discrimination based on health status. These barriers contribute to the growing population of uninsured. Second, private health insurance markets are not very organized, making it difficult for individuals and employers to effectively compare options based on price, benefits, and quality of service. The lack of cohesive information on comparability of plan options limits the ability of purchasers to make cost-effective choices for their coverage.

Third, there is little competition between insurers, a consequence of a substantial amount of consolidation among insurers and health care providers in recent years. With little incentive on the part of large consolidated providers to negotiate over price with insurers, and insurers with large market shares being able to pass on these costs to purchasers while continuing to increase their own profits, rapid growth in insurance premiums is fueled.

I believe that comprehensive health care reform will be necessary to address these problems. Insurance market reforms and subsidies to make coverage affordable for the modest-income population within the context of a more organized health insurance

market are essential strategies. A health insurance exchange can be developed to organize the insurance market and to provide guidance and oversight in achieving reform goals. Making a public health insurance plan option available to purchasers can further promote competition in insurance markets and could be an effective strategy for slowing health care cost growth.

Spreading Health Care Risk

Competition in private health insurance markets today focuses largely on obtaining the lowest-risk enrollees. With a highly skewed distribution of health expenditures—the top 10 percent of spenders account for nearly two-thirds of total health expenditures¹—the gains to insurers from excluding high-cost enrollees is tremendous. Insurance market regulations are required to prevent risk-selecting behavior by insurers. However, states allow insurers to risk select to varying degrees today so that they can protect themselves from the inherent nature of a voluntary insurance market, where individuals who expect to use significant health care services are those who are most likely to seek coverage. Without such leeway on the part of insurers, individuals may wait to purchase coverage until they know they need medical care, creating strong disincentives for the healthy to enroll. This dynamic would lead to very high premiums, reflecting a high-cost group of enrollees, and compromising the long-run stability of insurance pools. However, the consequences of allowing insurers to use such strategies are that many who need coverage cannot obtain it, and many more who have some type of insurance may not have adequate coverage to meet their health care needs.

¹ Samuel Zuvekas and Joel Cohen, “Prescription Drugs and the Changing Concentration of Health Care Expenditures,” *Health Affairs*, vol. 26, no. 1 (2007): 249–57.

In the context of a health care system that is universal—where everyone is insured all of the time—there is no longer any reason to allow discrimination by health status. Consequently, coverage denials, benefit riders, pre-existing condition exclusions, and medical underwriting can be prohibited, and the costs of those with high medical needs can be spread broadly across the population. Without universal coverage, insurer discrimination by health status can only be eliminated in tandem with broad-based subsidization of the high medical need population, ideally using a source of revenue that is unrelated to the decision to purchase insurance coverage.²

In a context of universal or near-universal coverage that includes subsidies for the low-income population and possibly for the high-risk population and prohibits insurer discrimination by health status, an exchange can play an important role related to ensuring the broad-based spreading of health care risk. An exchange can penalize or exclude from participation companies that violate insurance market regulations, establishing market conduct rules to prevent evasion of regulations through informal means. Requiring enrollment through a centralized place, for example, can prevent carriers from denying coverage to particular groups with poor risk profiles or actively marketing only to the healthy. An exchange can also provide for risk adjustment to account for any uneven distribution of enrollee risks across insurers, requiring participating insurers to provide sufficient data on their health plan enrollees. With more accurate risk adjusters, exchanges can maintain a more diverse group of plan options, including highly managed and less tightly managed plans.

² See for example, John Holahan, Len Nichols, and Linda Blumberg, “Expanding Health Insurance Coverage: A New Federal/State Approach,” in *Covering America – Real Remedies for the Uninsured*, Jack Meyer and Elliot Wicks, eds., Economic and Social Research Institute, 2001, available at http://www.urban.org/UploadedPDF/1000224_holahanuninsuredproposal.pdf.

If the exchange is the exclusive health insurance marketplace for some portion of the population (e.g., individual purchasers and some small groups), then opportunities for steering risks to alternative markets are eliminated. However, if insurers and purchasers can choose whether to participate in the exchange or whether to purchase coverage elsewhere, some risk segmentation potential will remain. In such a case, careful monitoring of the health risks of the enrolling and disenrolling populations will be important for the exchange to maintain, as risk adjustment between the exchange and non-exchange markets may be necessary to maintain the stability of all pools.

Delivering Health Insurance Subsidies

Exchanges can also be designed to efficiently deliver health insurance subsidies, an essential element of a reform intended to make coverage affordable for all incomes. Centralizing the subsidy determination and the process by which subsidy payments are made to insurers into a single agency, such as an exchange, would be a much more efficient approach to administration than that under the Health Coverage Tax Credit (HCTC) experience. Under the HCTC, a non-means-tested program that subsidizes coverage in the existing varied private insurance markets, roughly 34 percent of total spending for the program is attributable to the costs of administering the subsidy.³ Processes for determining eligibility and for making appropriate payments to hundreds of different health plans require many separate transactions that are performed by multiple agencies under that program.

Having all of these processes centralized in one place could appreciably increase the efficiency of delivering subsidies. This one-stop-shopping approach has been taken

³ Stan Dorn, "Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons," Urban Institute Health Policy Center issue brief, 2008, <http://www.urban.org/url.cfm?ID=411608>.

on by the Massachusetts Connector—an example of one type of exchange—with much success. Allowing the exchange to standardize plans, limit the number of vendors, and reduce the number of transactions would also lower administrative costs.

Ensuring Meaningful Coverage

The exchange could exclude plans not meeting minimum coverage standards, ensuring that all have access to meaningful coverage. Such minimum coverage standards will also reinforce risk spreading. If a common set of benefits are covered by all plans, but some variation in cost-sharing requirements is allowed, individuals will be less likely to choose plans based upon their health status. Conversely, allowing healthy individuals to opt out of coverage for benefits that will be needed by those with serious health conditions—for example, prescription drugs—will tend to separate purchasers into different plans by expected use of services. Over time, that segmentation will increase, making it difficult to maintain the type of coverage that meets the needs of those with serious conditions, as the average cost of those policies that include the extra benefits would quickly rise. On the other hand, if all individuals—healthy and sick—have policies that include these benefits, the marginal cost of the benefit for each individual can be quite low.

Of course, agreement on the definition of “adequate” coverage will be politically controversial. An exchange could be delegated the responsibility of determining adequate coverage (as was the case in Massachusetts), or that role could be played by another independent agency. The exchange would be responsible for determining that all coverage sold within it meets minimum adequacy standards. Other minimum standards

might include requirements for provider networks, prompt claims payment, appeal and grievance procedures, and so on, all of which could be verified by the exchange.

Cost Containment

Exchanges can also play an important role in cost containment. The lack of competitive pressures in the current insurance market leads to higher prices and less cost-efficient practice patterns. Insurance markets are dominated by a small number of larger insurers. Robinson showed that in 2003, in all but 14 states, three or fewer insurers accounted for 65 percent of the commercial insurance market.⁴ He also found that 34 states had Herfindahl-Hirschman Indices of greater than 1,800, the level at which the Department of Justice and the Federal Trade Commission guidelines deem markets of antitrust concern. The Robinson analysis also found that while medical care costs grew significantly faster than inflation during the 2000 to 2003 period, private insurer revenue grew even faster. In other words, the insurers' market power allowed them to pass on health care costs to purchasers and increase their own profitability at the same time.

Meanwhile, the dominant insurers do not seem to use their market power to drive down provider prices. First, they do not believe that they can maintain market share without the flagship hospitals, making those providers unwilling to negotiate. Second, lack of information in the market doesn't allow individuals to effectively shop for plans based upon benefits, price, and quality, diminishing the need to aggressively bargain with providers. Third, small insurers appear to follow the pricing lead of the large ones, not lower prices in an attempt to gain market share. And fourth, hospital system consolidation severely limits insurers' ability to negotiate for lower rates. In fact, 88

⁴ James C. Robinson, "Consolidation and Transformation of Competing in Health Insurance," *Health Affairs*, vol. 23, no. 6 (2004): 11–24.

percent of large metropolitan areas are in highly concentrated hospital markets as defined by the Federal Trade Commission and the Department of Justice.⁵

An exchange can be given the authority to negotiate with health insurers over premiums. They could also be allowed to exclude insurers from exchange participation based upon premium price or growth. Both of these tools would provide greater incentives for insurers to negotiate lower prices with providers and to hold down premium rates relative to current trends. Such rate negotiation is not done by state insurance departments. If an exchange required plans to offer similar insurance packages, this would also promote greater competition, as purchasers would have the ability to more easily compare price differences across plans. Understanding of plan options could be further enhanced by the exchange providing improved information materials to consumers.

Employers participating in an exchange can be required to make fixed contributions for their workers, regardless of which plan they choose. This approach would provide incentives for workers to choose lower-cost plans, as they would have to pay the difference for more expensive options out of pocket. To the extent that an exchange could also reduce marketing expenses associated with insurance by centralizing this function, costs could be reduced further.

A Public Plan Option within an Exchange. Adding a public plan option to those offered *within* an exchange would significantly increase the cost-containment potential of reform. A public plan could be modeled after the traditional Medicare program, paying

⁵ V. B. Vogt and R. Town, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?* Robert Wood Johnson Foundation Research synthesis report 9, February 2006; and Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition*, 2004, http://www.usdoj.gov/atr/public/health_care/204694.htm.

providers based upon the payment systems Medicare uses, but with different cost-sharing rules and possibly some differences in covered benefits. The latter would be necessary to make the plan(s) consistent with benefit and cost-sharing requirements within the exchange. Payment rates could be set between Medicare and private rates, at least in the early years of reform. Medicare payment policies have been shown to reduce cost growth relative to private insurers.⁶

A public plan with significant market share could create the competitive pressures necessary to induce private insurers to be tougher negotiators with their participating providers. The public plan could also be an innovator in the development of other cost-containment mechanisms; given its role as an arm of the federal government, it would have a strong interest in doing so. A public plan would also provide a lower-administrative cost option for purchasers, as several analyses have shown the existing public plans have significantly lower administrative costs than private plans.⁷ Such an option would likely put pressure on private insurers to hold down their own costs.

Of course there are limits to the extent of savings that can be achieved through adopting Medicare payment strategies for the nonelderly population as well as limits to the administrative savings available. The government is unlikely to use all of the market power that it has available because it also has the responsibility of maintaining a stable health care system. If payments to providers are held down too much, there is a risk of hospital closures, slowing the dispersion of new technologies more than is desirable and

⁶ Cristina Boccuti and Marilyn Moon, “Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades,” *Health Affairs*, vol. 22, no. 2 (2003): 230–37; Chapin White, “Why Did Medicare Spending Growth Slow Down?” *Health Affairs*, vol. 27, no. 3 (2008): 793–802.

⁷ See, for example, Merrill Matthews, *Medicare’s Hidden Administrative Costs: A Comparison of Medicare in the Private Sector* (Council for Affordable Health Insurance, 2006); and Congressional Budget Office, *Designing a Premium Support System for Medicare* (November 2006).

limiting access to physician services. Political pressure also tends to limit the willingness of government to aggressively contain costs. This is evident from recent experience with the sustainable growth-rate policy, approval of computed tomography angiography by Medicare carriers (despite limited research evidence to support it), and unwillingness to let Medicare negotiate with drug companies over prescription drug prices. On the administrative-cost side, any public plan will still require claims processing, claims and utilization review, care management, premium collection, and marketing. Thus, while administrative costs would likely be lower in a new public plan than in private insurance, they probably would not be as low as in current public plans. Market reforms would also reduce some administrative costs in private plans.

For these reasons I do not believe that a public plan option would destroy the private insurance market or lead to a government takeover of insurance, as some fear. Nor would it be fully successful in controlling cost growth. Realistically, a public plan would most likely lead to some cost control but would be limited to some extent by the issues raised above. In such an environment, those private plans that offer high-quality services and good access to providers would survive the competition, even some with higher costs than the public option. Those that innovate and offer limited networks may even be able to offer lower-cost plans than the public alternative. The continuing presence of private plans would constrain how aggressive a public plan could be in holding down payment rates—if providers are not kept reasonably happy, enrollees would move to private plans. Meanwhile, the presence of the public plan would force private insurers to compete on price, which does not happen much today. Those private insurers not adding much value are likely to disappear from the market in the face of real

competition, but those offering a superior product through efficiency, consumer satisfaction, and ease of access to high-quality services will survive in the face of it. Innovation in cost containment should be enhanced among private plans as well.

Conclusion

The significant shortcomings of current health insurance markets mean that the list of goals for reform is lengthy. Insurance market regulations that would substantially broaden the spreading of health care risk, subsidies to make coverage affordable for all incomes, and greater organization of health care markets should be considered essential components of reform. Serious cost-containment measures will be critical to ensuring the long-run stability of any comprehensive system of reforms. Establishing a health insurance exchange can facilitate the spreading of health care risk, delivering health care subsidies, ensuring meaningful coverage, and containing health care costs. Adding a public insurance plan option to the exchange is a very promising catalyst for cost containment, and one that would be a considerably less dramatic change than other promising options, such as having the exchange negotiate rates on behalf of all participating plans or moving to an all-payer rate-setting system.